UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA

CHRISTOPHER L. CARSON, individually
as Co-Executor of the Estate of Asa E. Carson, Deceased

Plaintiff,

v. Case No. 3:14-cv-16544

UNITED STATES OF AMERICA,

Defendant.

****

COMPLAINT

Now comes Christopher L. Carson, as Co-Executor of the Estate of Asa E. Carson, deceased, Plaintiff herein, files this lawsuit, against the Defendant the United States of America and in support thereof states as follows:

FACTS

1. That the Plaintiff files this complaint pursuant to the Federal Tort Claims Act, 28 U.S.C. § 2671, et seq.

2. That the Unites States District Court Southern District of West Virginia is the appropriate venue for this claim as the incident(s) of improper credentialing/privileging and medical malpractice occurred due to the actions of the Defendant, the United States of America,

through the negligence of its employees of the United States Department of Veterans Affairs, Huntington Veterans Affairs Medical Center (VAMC) located at 1540 Spring Valley Drive, Huntington, Cabell County, West Virginia.

3. That the Plaintiff, properly prepared and filed two claims using the Standard Form 95 under the Federal Tort Claims Act within the statute of limitations and the United States Department of Veterans Affairs accepted and reviewed the claims. The claims were filed for the United States Department of Veterans Affairs improper hiring, credentialing and privileging of Dr. Robert K. Finley, III and medical malpractice by Dr. Robert K. Finley, III. The United States Department of Veterans Affairs denied the claim for improper hiring, credentialing and privileging of Dr. Robert K. Finley, III on November 18, 2013 (see Exhibit 1) and approved the medical malpractice claim on or about December 5, 2013 (see Exhibit 2).

COUNT I (Negligence – Credentialing/Privileging)

4. That the Defendant, the United States of America, Huntington VAMC on or about July 2007 hired, credentialed and privileged, a physician, Dr. Robert K. Finley, III, as a Temporary Surgical Oncologist (Not to exceed 13 Months), while under investigation by the Iowa Board of Medicine for actions which raised "serious concerns" regarding the treatment of nine surgical patients under the care of Dr. Robert K. Finley, III during a thirteen month period between January 3, 2005 and January 11, 2006.

5. That the Defendant, the United States of America, Huntington VAMC employee, Chief of Surgical Services, Dr. Tim Canterbury, on or about January 29, 2010 presented information to the Huntington VAMC Special Professional Standard Board on Dr. Robert K. Finley, III regarding renewal of clinical privileges and stated that the Iowa Medical Board

investigation was discussed at great length with Dr. Robert K. Finley, III upon his initial hiring and "it was decided the cases had no merit" (see Exhibit 3).

6. That the Defendant, United States of America, Huntington VAMC, through its employees hired, credential and privileged and retained Dr. Robert K. Finley, III, a general surgeon with specialties in surgical oncology and head and neck surgery that led to Asa E. Carson (Mr. Carson) being forced to rely on the Huntington VAMC's choice of Dr. Robert K. Finley, III, as the attending Surgical Physician in an emergency situation, a physician that was under investigation by the Iowa Board of Medicine due to the failure to exercise appropriate surgical judgment, surgical performance and post-operative management and failure to refer patients to a more experienced surgical team. A choice by the U.S. Department of Veterans Affairs that led Mr. Carson to experience sub-standard care as demonstrated in the medical malpractice Standard Form 95 claim approved by the United Stated Department of Veterans Affairs.

7. That between May 29, 2011 to June 17, 2011, Mr. Carson was forced to rely on the Huntington VAMC's choice of Dr. Robert K. Finley, III, a physician that was in settlement negotiations with the Iowa Board of Medicine while he was performing multiple failed surgeries on Mr. Carson under hospital privileges that were negligently provided to Dr. Robert K. Finley, III to include the following surgical procedures: exploratory laparotomy, sigmoid resection and Hartmann procedure with end colostomy and Hartmann pouch (May 29, 2011); revision of colostomy with ileostomy and wound vac closure of the abdomen (June 6, 2011); wound vac change with debridement (June 9, 2011); change of wound vac and debridement of abdominal wound (June 13, 2011); and change of wound vac, exploratory laparotomy, and end descending

mucous fistula with irrigation of abdomen and placement of naso-jejunal feeding tube (June 16, 2011).

8. That on June 16, 2011 upon Mr. Carson returning from the operating room to the Huntington Veterans Affairs Medical Center Intensive Care Unit (ICU) in critical condition a Veterans Affairs ICU nurse expressed his concern to a family member of Mr. Carson that the patient, Mr. Carson, was not receiving adequate care from Dr. Robert K. Finley, III.

9. That on June 16, 2011 the family of Mr. Carson requested a patient advocate meeting to discuss the care provided by Dr. Robert K. Finley, III and during the patient advocate meeting on June 17, 2011 requested that no future care be provided by Dr. Robert K Finley, III to Mr. Carson and requested based on the advice of Huntington VAMC Acting Chief of Surgical Services, Dr. John Walker, that Dr. David Denning, a board certified surgeon for Critical Care and Chairman of the Department of Surgery at the Marshall University Joan C. Edwards School of Medicine, to be the primary consulting surgical physician to Mr. Carson. On June 20, 2011, Dr. David Denning agreed to become Mr. Carson's primary consulting surgical physician with all Huntington VAMC care by surgical residents for Mr. Carson to be reported directly to Dr. David Denning.

10. That on June 30, 2011 Dr. Robert K. Finley, III settled the charges brought by the Iowa Board of Medicine agreeing to being CITED for "failing to conform to the minimal standard of practice of medicine in Iowa. Dr. Robert K. Finley, III is warned that such practice in the future may result in further formal disciplinary action, including suspension or revocation of his Iowa medical license." Dr. Robert K. Finley, III agreed to pay a civil penalty of $5000 (see Exhibit 4). The Iowa Board of Medicine charges included a description of care provided by Dr. Robert K. Finley, III to an individual identified as Patient #9 that "underwent a right

hemicolectomy and ileotransverse colostomy anastomosis and the patient died following serious postoperative complications."

11. That the Defendant, through its employees hired, credentialed, privileged and retained Dr. Robert K. Finley, III, and granted continued hospital privileges by dismissing the Iowa Board of Medicine charges as simply having "no merit."

12. That the Defendant ignored Dr. Robert K. Finley, III's "database" statistics that measured surgical outcomes in terms of specific physician's rate of patients return to the operating room and death rates in which Dr. Robert K. Finley, III states in regard to the database that "in the area of colon resections my results were not as good as the database."

13. The Defendants negligent hiring led to Mr. Carson being forced to rely on Dr. Robert K. Finley, III for treatment in an emergency situation that resulted in Mr. Carson to experience conscious pain and suffering, bodily disfigurement and the loss of quality of life up until his death.

14. WHEREFORE: The Plaintiff claims damages against the United States of America in an amount of $1,200,000 and for any further relief that this Honorable Court determines necessary and appropriate.

COUNT II (Negligence – Medical Malpractice)

15. That on May 29, 2011, the Defendant, United States of America, Huntington VAMC, through its employee, Dr. Robert K. Finley, III failed to exercise the minimal standard of care to Mr. Carson by not performing standard diagnostic testing, such as a CT scan or abdominal radiographs, to a patient exhibiting a left lingual hernia and diffuse abdominal pain that is indicative of possible bowel obstruction, perforation or ischemia that would require urgent surgical intervention. Dr. Robert K. Finley, III incorrectly diagnosed Mr. Carson, a patient with

an elevated white blood cell count and diffuse abdominal pain, with an inguinal hernia when he in fact had perforated diverticulitis. Dr. Robert K. Finley, III's failed assessment resulted in Mr. Carson being discharged from the Huntington VAMC and which delayed the correct diagnosis from being made. This delay in diagnosis contributed directly to the complications suffered by Mr. Carson.

16. That on May 29, 2011 Mr. Carson returned to the Huntington VAMC in a significantly deteriorated condition. It took approximately 14 hours after Mr. Carson presented to the Huntington VAMC emergency room for the diagnosis of perforated sigmoid diverticulitis with diffuse peritonitis. This delay in treatment contributed directly to the complications suffered by Mr. Carson.

17. That on May 29, 2011 Dr. Robert K. Finley, III performed an exploratory laparotomy, sigmoid resection and Hartmann procedure with end-colostomy and Hartmann Pouch due to a perforated colon of Mr. Carson, a procedure that Dr. Robert K. Finley, III personally describes as a procedure in which he falls below the standard of outcomes compared to other physicians performing the procedure. As a result of his poor performance, he created an ischemic, retracted colostomy.

18. That between May 29, and June 6, 2011 Dr. Robert K. Finley, III failed to exercise the standard level of care in the treatment of Mr. Carson by repeatedly ignoring and failing to recognize in a timely fashion the deteriorating condition of a necrotic and retracted ostomy and on-going septic condition of Mr. Carson. Had the condition of the ostomy been properly recognized in a timely fashion, the colostomy could have been revised without the severe contamination and necrosis of the abdominal cavity and abdominal wall.

19. That on June 6, 2011 nine days after the initial surgery, Dr. Robert K. Finley, III upon examination of the necrotic and ruptured ostomy via a contrast study discovered that contamination (stool) was continuing to leak into Mr. Carson's abdominal cavity. Despite his poor outcomes with colon resection, he failed to refer the patient to a higher level of care. Due to delay in diagnosis of the necrosis of the colostomy, the infection from the leaking colostomy destroyed a portion of Mr. Carson's abdominal wall. Dr. Robert K. Finley, III went on to perform a revision of the existing colostomy with a new ileostomy and wound vac closure of the abdomen with extensive debridement (removal) of the abdominal wall which ultimately resulted in a massive hernia.

20. That on June 16, 2011 Dr. Robert K. Finley, III again in the operating room performed another surgery on Mr. Carson and once again "saw the stool in the wound" and a mucous fistula with irrigation of the abdomen and placement of naso-jejunal feeding tube was performed. Had a mucous fistula been performed at the previous operation, the additional contamination of the abdomen would not have occurred. He once again failed to defer to a board certified colon and rectal surgeon or a general surgeon with better outcomes of colon resections. The additional contamination of the abdominal cavity and abdominal wall lead to the ongoing destruction of Mr. Carson's abdominal wall.

21. That on June 16, 2011 upon Mr. Carson returning from the operating room to the Huntington VAMC Intensive Care Unit (ICU) in critical condition, a Veterans Affairs ICU nurse expressed his concern to a family member of Mr. Carson's that the patient, Mr. Carson, was not receiving adequate care from Dr. Robert K. Finley, III.

22. That on June 17, 2011 the family of Mr. Carson requested a patient advocate meeting to discuss the care provided by Dr. Robert K. Finley, III and requested that no future

care be provided by Dr. Robert K Finley, III to Mr. Carson and requested a consulting physician, Dr. David Denning, a board certified surgeon for Critical Care and Chairman of the Department of Surgery at the Marshall University Joan C. Edwards School of Medicine.

23. That due to the substandard care of Dr. Robert K Finley, III, Mr. Carson was forced to endure multiple colon resections, revisions and placement of ostomies and continued abdominal wall debridement that led to a massive abdominal hernia, a bodily disfigurement (see Exhibit 5). Mr. Carson suffered due to inadequate ostomy placement resulting in ongoing challenges due to leakage of ostomy appliances and complications from the abdominal hernia with the remainder of his life in and out of the hospital. Mr. Carson died on May 21, 2013 approximately a week after an attempted elective surgery by Dr. David Denning on Mr. Carson in an effort to restore his quality of life and reverse the complications due to surgeries performed by Dr. Robert K. Finley, III.

24. That as a direct and proximate result of the breach of the applicable standard of medical care by Dr. Robert K. Finley, III, which resulted in Mr. Carson to: 1) endure conscious pain and suffering, 2) mental anguish, 3) and permanent physical injuries and bodily disfigurement, and 4) was required to undergo additional medical procedures.

25. That the injuries and damages sustained to Mr. Carson were the direct and proximate result of the negligent actions of the Defendant, the United States of America, through the negligence of its employees, Dr. Robert K. Finley, III of the United States Department of Veterans Affairs, Huntington Veterans Affairs Medical Center located at 1540 Spring Valley Drive, Huntington, Cabell County, West Virginia.

WHEREFORE: The Plaintiff claims damages against the United States of America in an amount of $600,000 and for any further relief that this Honorable Court determines necessary and appropriate.

Respectfully submitted,

CHRISTOPHER L. CARSON

Christopher L. Carson

1212 10th Street
Huntington, West Virginia 25701
(304) 697-2066